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United States Government Accountability Office
Washington, DC 20548

August 2, 2011

The Honorable Geoff Davis
Chairman
Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

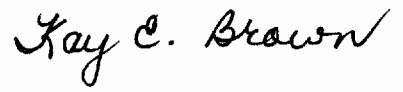
Subject: Responses to Questions for the Record -- Hearing Entitled *Child Deaths Due to Maltreatment*

Dear Mr. Chairman:

This letter responds to your July 14, 2011 request that we address questions for the record related to the Subcommittee's July 12, 2011 hearing on child deaths due to maltreatment. Our responses to the questions, which are in the enclosure, are based on our previous work and knowledge of the subjects raised by the questions, unless otherwise noted.

If you have any questions about the letter or need additional information, please contact me at (202) 512-7215 or brownke@gao.gov.

Sincerely yours,



Kay E. Brown
Director, Education, Workforce,
and Income Security Issues

Enclosure

RESPONSE TO POST-HEARING QUESTIONS FOR THE RECORD

Child Deaths Due to Maltreatment

Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

July 12, 2011

Questions for Kay E. Brown
Director, Education, Workforce, and Income Security
U.S. Government Accountability Office

Questions for the Record Submitted by Chairman Geoff Davis

1) On confidentiality standards, several witnesses raised this as an issue that could be addressed to improve understanding of the number of children who die from maltreatment. In general, what would be required to loosen privacy and confidentiality standards so agencies could more easily share data on maltreatment, including in cases where children have died from maltreatment and this information might prevent subsequent deaths? Does this require Federal action, such as by HHS? State action? Something else?

In the GAO report that was the focus of our testimony on July 12th (GAO-11-599), we recommended that HHS help states strengthen the completeness and reliability of National Child Abuse and Neglect Data System (NCANDS) data on child fatalities from maltreatment by identifying best practices, including those that help address privacy and confidentiality concerns and foster cross-agency coordination. We believe that this recommendation, if fully implemented by HHS, would facilitate improved information sharing across state and local agencies on child fatalities from maltreatment. Specifically, ensuring that state officials involved in child protection issues are well educated about the requirements and prohibitions of applicable privacy and confidentiality laws could help state and local agencies overcome some of the barriers to information sharing. While such laws are generally intended to ensure that sensitive personal information is protected from public disclosure, these laws often permit information sharing under certain circumstances, such as for law

enforcement purposes. As a result, these laws may already permit agencies to share certain kinds of information related to child maltreatment fatalities. To facilitate this process, in implementing our recommendation, HHS could re-emphasize the importance of sharing information related to child maltreatment fatalities, help states identify the constraints and concerns about confidentiality and privacy laws, and provide guidance to facilitate information sharing among state agencies on child maltreatment fatalities. Such steps could play an important role in educating state and local officials on the front lines of child protection about the circumstances under which this information can be shared across state agencies and localities, consistent with the requirements and prohibitions of applicable laws. The Federal Interagency Work Group on Child Abuse and Neglect could also be another vehicle for clarifying requirements and exceptions to these laws so that cognizant officials can distinguish between actual and perceived legal impediments to needed information sharing.

In addition, HHS could identify successful or promising strategies that some state and local child welfare agencies have used to obtain critical data from other agencies that have enabled them to better track child maltreatment deaths and enhance the completeness of national data on these child fatalities. For example, California has a data sharing agreement between the child welfare department and the department of public health, and the state coordinates across multiple agencies to produce a more accurate estimate of child maltreatment fatalities, according to officials we interviewed. Negotiating and implementing an inter-agency MOU may help ensure that the appropriate mechanisms are in place to permit information sharing when there is a time-sensitive need to do so.

2) **You make a number of recommendations in your report about how to improve our knowledge of the number of children who die from maltreatment, including those who were not previously involved with the child welfare system. Are there any specific changes that Congress could make to improve the quality and accuracy of data collected by HHS, by child death review teams, or others? How about other Federal actors such as HHS? If so, what changes do you believe would improve our knowledge? Would making such changes cost money or add significant complexity in terms of child welfare or other systems?**

We believe our recommendations to HHS, if fully implemented, would lead to improvements in the comprehensiveness of data collected by HHS and our knowledge about the children who die from maltreatment, without requiring changes from Congress. For example, HHS' guidance for reporting NCANDS data encourages states to reach out to other state agencies; however, as noted in our report, nearly half of state agencies reported in our survey that they were not including information from other state agencies—such as Child Death Review Teams, law enforcement, and health departments—on child fatalities from maltreatment in their NCANDS data. In implementing our recommendation, HHS should therefore underscore the importance of obtaining information from other state and local agencies and entities so as to help states strengthen the completeness and reliability of data they report to NCANDs. In addition, our recommendations to expand the information HHS makes public on the circumstances of child fatalities from maltreatment and to routinely share analyses and expertise on the circumstances of child maltreatment fatalities, if fully implemented, would also improve our knowledge about these fatalities.

In our judgment, the recommendations we made in our report could be implemented without necessarily requiring significant increases in funding or additional complexity. For example, identifying best practices for strengthening collaboration among state or community partners on child maltreatment fatalities could entail discussions with state officials at annual NCANDS meetings or use of the Web-based portal for NCANDS state officials. Routinely sharing information on the circumstances of child maltreatment fatalities could be achieved by making greater use of existing interagency work groups and other mechanisms. To improve our knowledge of these issues, HHS could also, for example, analyze NCANDS and other data more thoroughly on the circumstances surrounding the deaths of children who were disproportionately fatally maltreated, such as children under 4 years of age. These and other such efforts may not require significant expenditures or add complexity to current programs.

3) Do we know anything about the timing of child deaths due to maltreatment? For example, do more deaths among older children occur in summer months when school is out and children are more likely to be under a parent's

supervision only? Among younger children on weekends when they may not be in day care? Around holidays when there may be more drinking or stress in the home? At the beginning of the month when government benefit checks arrive, or the end of the month when those funds may have run out?

To respond to your question on whether timing is a factor related to child deaths from maltreatment,[1] we identified three studies. Collectively, the studies provide conflicting information regarding this issue. A study published in 2002—covering the years 1976 to 1998—found that child homicide risk increased for infants, toddlers, and preschoolers during the winter and increased for primary and middle school children during the summer. However, a 2010 study of death certificate data for children younger than age 5 found that child homicides occurred uniformly throughout the year. Also, a 2006 study of data from the Center for Disease Control and Prevention's National Violent Death Reporting System for children ages 0 to 4 found no evidence of a pattern between child homicide and certain days of the week.[2] We note, however, that we did not fully assess the methodological soundness of these studies, nor was our search comprehensive. Other research may be found with additional search efforts.

For understanding the circumstances under which child fatalities from maltreatment occur, a key issue is whether children are in a setting where they are visible to professionals—such as day care providers, police officers, doctors, teachers, and other professionals—who are generally mandated to report suspected child abuse and were responsible for nearly 60 percent of all reports of suspected maltreatment to child protective services in fiscal year 2009. According to NCANDS data, the youngest children–under age 4—are at the highest risk of fatal maltreatment: Such children may spend much of their time at home with a parent and may not be in day care or another setting where they can be seen by a mandatory reporter.

[1] In our July report, we noted that the NCANDS data system does not ask states to identify the date of a child's death and that establishing maltreatment as the cause of death can take many months, particularly when a criminal proceeding is involved.

[2]Richard McCleary and Kenneth S.Y. Chew, "Winter Is the Infanticide Season: Seasonal Risk for Child Homicide," *Homicide Studies* (Aug. 2002); Antoinette L. Laskey, et al, "Seasonality of Child Homicide." *The Journal of Pediatrics*, Volume 157, Issue 1, July 2010, M. D. Bennett, Jr. et al, "Homicide of children aged 0–4 years, 2003–04: results from the National Violent Death Reporting System," *Injury Prevention*, 2006;12.